

IDENTIFYING BARRIERS TO ACCESSING AND ESTABLISHING  
PRIMARY CARE SERVICES AMONG INSURED PATIENTS WHO ARE  
“SUPER-USERS” OF EMERGENCY DEPARTMENTS (EDS)

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## ABSTRACT

**Introduction:** The overuse of the ED for management of chronic disease results in fragmentation of care, often duplicates services, and is costly. Barriers to accessing care in ambulatory care services may increase ED use for chronic disease management. There are few studies that have explored the barriers to accessing primary care services among both private and publicly insured adults.

**Purpose:** The purpose of this qualitative descriptive study is to identify the barriers to accessing primary care services among insured individuals identified as using the ED for chronic disease management.

**Methodology:** Qualitative descriptive method guided data collection and analysis. A purposive sample of insured adults from Family Medicine clinic participated in two focus groups. Data were collected through audio-recordings of the focus groups and participant observation. The audio-recordings were transcribed verbatim by a professional transcriptionist and reviewed by the research team members while listening to the audio-recordings. Preliminary codes were developed and collapsed into themes.

**Preliminary Results:** Although the purpose of this study was to identify barriers to accessing primary care services, the preliminary findings from this small sample suggest that there are not significant barriers to accessing primary care services. Participants did discuss factors that increased utilization of services in ambulatory care clinics, including reciprocal trusting relationships with providers, seamless entry into clinics, and strong support systems.

**Conclusions:** Further research is needed to continue to explore possible barriers and facilitators to accessing primary care services among a larger population of ED super-users. Additional research is needed with community members not engaged in any health care services.

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## INTRODUCTION

### BACKGROUND/SIGNIFICANCE

Emergency department (ED) use in the United States has increased dramatically over the past two decades, is a major contributor to wasteful health care spending, decreases the quality of care provided in the ED, and creates fragmentation of care (New England Health Institute, 2010). Between 1992 and 2005, ED visits increased by 28% (Weber et al., 2008). Inappropriate ED usage accounts for over \$38 billion in inefficient spending annually (New

England Health Institute, 2010). Additionally, ED usage is ineffective for management of chronic conditions because it does not provide the continuity of care individuals can expect from a primary care provider (New England Health Institute, 2010).

There has not been a clear consensus in the literature regarding whether the insured or uninsured populations are using the ED at higher rates. However, many sources continue to link the increasing rates of ED usage with individuals lacking health care insurance. However, the uninsured population was not the cause of the increased ED usage from 1992 to 2005 (Weber et al., 2008). Attributing the ED overuse issue solely to the uninsured population not only oversimplifies the problem but it also decreases the likelihood that politicians and hospital administration will support investments in innovative solutions because this population has low voter-turnout for public elections and is not paying for their health services (Weber et al., 2008). There are many alternative explanations for the increased ED usage, “including population increases, the aging of our population, [and] the increased numbers of time sensitive interventions requiring state-of-the-art hospital care” (Weber et al., 2008, p. 112). Furthermore, with the passage of the Affordable Care Act, approximately 32 million additional Americans will acquire health insurance by 2019. Because insured patients are more likely to use the emergency department, we can expect even greater ED usage in the near future (Carrier, Yee, & Holzwart, 2011).

## **PURPOSE/RESEARCH QUESTION**

The *purpose* of this qualitative descriptive study is to identify the barriers to accessing and establishing primary care services among insured patients of an academic

medical center Family Medicine ambulatory care clinic (FMACC) who are “super-users” of emergency departments (EDs).

## **LITERATURE REVIEW**

A literature search was conducted using the CINAHL and PubMed databases with the following limits: English language only and a date of publishing range from 2003-2013. Search terms utilized include: barriers to health care access, access to primary care services, and outpatient care and emergency department usage. Relevant articles identified through the literature search are reviewed individually. From these articles, several common barriers to accessing health care were reported. These barriers include difficulties understanding and navigating the health care system, transportation problems, the inability to pay for services, insensitive providers, and providers who lack knowledge of available resources.

Hines-Martin (2003) reported the results of the qualitative component of a larger mixed methods study evaluating barriers to accessing mental health care among African Americans. The participants in this study included 24 African American, low-income adults. The researchers identified many specific barriers that the participants faced in accessing mental health services. The barriers were categorized into individual, environmental, and institutional barriers. The most commonly expressed barriers were individual barriers such as lack of knowledge or understanding of the problem, and beliefs about seeking mental health services. An environmental barrier to seeking care expressed by the participants was the lack of information, support, and encouragement from others to seek treatment. Institutional barriers included negative impact of health care professionals’

attitudes, waiting time to be accepted for services, and guidelines for services that inhibit access to needed services. The findings of the study show a need for further research related to the stigma surrounded mental health problems in this population. Early intervention for individuals experiencing multiple stressors could help to prevent psychological illness. Interventions to reduce stress should assist families as a whole. The researchers also suggest a cost-benefits study of preventive approaches to mental illness would be useful in the current health care environment with decreased funding and resources.

Lewis and colleagues (2003) conducted a research study aimed to look at perceived barriers to health care for homeless women to predict unmet medical needs in this population. Homeless women (N=974) between the ages of 15 and 44 years old in Los Angeles County participated in the face to face interviews. The results showed that some of the barriers to receiving health care included lack of knowledge of where to go for health services, long office waiting times, and being too sick to find care. Additionally, the researchers found commonly mentioned facilitators of health care access for homeless women included free transportation, the ability to receive care for all health problems and social service needs in the same location, living in a house or apartment, weekend or evening clinic hours, and help from shelters or soup kitchens finding health care. Other facilitators of health care access mentioned by the participants included having a nurse or doctor come to them and receiving food or money at appointments. More than 81% of the women with children interviewed said having appointments at the same time and place as their kids would be beneficial. The researchers suggest educating the homeless women about available health care services when they access shelters and food programs.

Additionally, the health care clinics could provide additional needed services such as laundry and showering facilities while the women wait to see a provider. Free transportation to clinics and treatment for all health care issues and social services in one location are also interventions recommended by the researchers.

Wetta-Hall and colleagues (2005) conducted a qualitative study to explore emergency department use by uninsured individuals. Participants identified financial barriers, such as not being able to pay a \$65 charge for the office visit, or having unpaid bills with the physician's office. The participants indicated that these financial barriers led them to avoid seeking health care until their symptoms were severe. The participants also reported other barriers, such as inadequate transportation, inconvenient office hours, long wait times for appointments, not having a regular doctor, and poor relationships between patients and physicians. The participants indicated that they were not offered health insurance at their place of employment, but would buy the employer's insurance if it was available. To reduce their ED visits, the participants also indicated that ED physician referrals to primary care providers would be beneficial.

Cheatham and colleagues (2008), in a review of the literature, discussed the barriers and facilitators black men in the United States face to accessing health care. One facilitator for access to health care for black men described by the authors was military veteran status. The cost of prescription medications or ability to keep appointments was not a problem for veterans. Additionally, the authors recognized that religion could be either a facilitator or a barrier to individuals receiving health care. Religion serves as a facilitator when an individual recognizes his body as God's temple and feels responsible to care for it;

it serves as a barrier when the individual accepts illness as God's will. Another important facilitator for black men seeking and receiving health care is the health care provider's personal characteristics. Black men who were interviewed recognized that they valued providers who showed compassion, were truthful about the patients' health conditions, and were interested in other aspects of the patients' lives such as personal and social issues. The authors also recognized that certain studies found that black people preferred to have a black health care provider to eliminate feelings of racism and mistrust of the health care system. They also found that health care outreach programs would be a more effective facilitator to health care access for black men if they were held in places where these individuals congregate such as churches, health clubs, and barbershops. Finally, in another study they reviewed in their article, black men recognized women family members as important encouragers for seeking health care.

Nandi and colleagues (2008) looked at undocumented Mexican immigrants' access to health services in New York City. In this study, participants were 18 years or older, born in Mexico, and current residents of New York City. There were 431 respondents in this study based on the criteria on undocumented status. The researchers found that the women interviewed were almost three times more likely than men to have a regular health care provider. The researchers also found that respondents who arrived in the United States before 1997 were more likely to receive regular health care services than those who arrived after that year. This is consistent with previous findings that access to health care services increases with increased time in the United States. The researchers suggest this occurs because the individuals become more familiar with the U.S. health care system and learn how to navigate it. The researchers found that financial and social resources are

important determinants of health insurance coverage and access to a regular provider among undocumented Mexican immigrants, even after accounting for differences in health need. The authors also discussed legislation that could create a barrier to immigrants accessing care: "In 1996, the United States passed legislation that further restricted the provision of many publicly funded services to undocumented immigrants, making it perhaps even more difficult to obtain health services than it was before the legislation" (Nandi et al., 2008, p. 2016). Another barrier to accessing health care common to many respondents was the fear of being discovered by government officials.

Robinson and colleagues (2008) conducted a systematic review of ten studies related to intimate partner violence. In each of the studies reviewed, victims of domestic violence were either interviewed, participated in focus groups, or completed questionnaires. Victims expressed several barriers to accessing care such as a lack of privacy, a fear of the consequences of disclosing domestic violence (such as fear that children would be removed from the home), and feelings of guilt, shame, and powerlessness. An additional recurring theme was victims' perception of lack of understanding or inappropriate responses by healthcare providers when discussing domestic violence. Based on these findings, the authors concluded health care professionals and policy makers needed to consider the location and timing of domestic violence services. Also, all health care professionals should be educated about domestic violence and child protection. Perceived barriers to accessing care also need to be addressed in health care. Last, victims of domestic violence need more consultations with providers during the help-seeking process.



Hudson and colleagues (2010) conducted a study to determine homeless young adults' perspectives on facilitators and barriers to receiving health care as well as to determine how the existing health care programs for this population can be improved. The participants included 24 homeless youth. Several participants reported the need for better access to mental health services. In addition, participants commented on the long wait times at health clinics and the limited days and times that these clinics were open. Participants also commented on the perception that society was trying to make the homeless population invisible and arrest them for being on the streets rather than helping them find help. Some implications for practice based on these findings include the need for increased community resources and providers who are well informed of outreach programs for homeless young people.

Gindi and colleagues (2012) provided insight into the reasons adults aged 18-64 seek emergency department health services. Patients' responses to questions on the National Health Interview Survey (NHIS) were utilized to draw conclusions about emergency department usage. The researchers found that 79.9% of individuals surveyed who visited the emergency department in 2011 did so because of a lack of access to other health care providers.

There were several common barriers to accessing health care reported across the articles including difficulties understanding and navigating the health care system, transportation problems, the inability to pay for services, insensitive providers, and providers who lack knowledge of available resources. Some implications for practice include the need for increased community health care resources with extended hours and

times, the need for free transportation to medical appointments, increased awareness on behalf of providers of available resources, and improved dissemination of information regarding these resources. There is a lack of information in the current literature looking globally at insured adults and there is minimal information on factors that serve as facilitators to accessing primary care services.

The results of the literature review indicated that many studies have been conducted to learn more about specific populations' primary care access challenges. These specific populations of people, including African Americans in need of mental health services, homeless youth, homeless women, victims of domestic violence, undocumented Mexican immigrants, and uninsured individuals have specific health care access concerns and needs. Our study aims to identify the barriers to accessing and engaging in primary care services among a wide range of publicly and privately insured individuals.

## METHODS

The purpose of this study was to identify the barriers to accessing and establishing primary care services among insured patients of an academic medical center Family Medicine ambulatory care clinic (FMACC) who are "super-users" of emergency departments (EDs). Qualitative descriptive method was used for data collection and analysis. To ensure minimal harm to participants, the research team's study protocol was granted approval from the medical center Institutional Review Board prior to data collection and analysis. Additionally, the researchers have completed the Institutional Review Board Conduct of Scientific Research modules prior to beginning data collection;

this provides documentation that the researchers have been trained in ethical conduct of scientific research.

## **RECRUITMENT AND DATA COLLECTION**

A Family Medicine RN Coordinator contacted patients who met the inclusion criteria, (adults the over the age of 18 years; ED super-user; referred to Family Medicine clinic; public or private insurance), explained the purpose of the study, and asked for permission for the research team to contact them about participating in the study. To this point in time, 12 patients provided permission to be contacted. Student assistants contacted the potential participants via telephone. The focus groups were conducted in the evening on a medical center campus in a private room. During the focus groups, the researchers obtained informed consent. One investigator facilitated the sessions using a semi-structured interview format (Appendix) and one investigator recorded the sessions. Participants were provided a monetary incentive. The focus groups were audio recorded and a professional transcriber cleaned the information of personal identifiers.

## **DATA ANALYSIS**

The researchers read through the transcripts along with their own written notes from the focus groups and listened to audio recordings. The transcripts were read again to identify codes with the purpose of the research study in mind. Codes were categorized and preliminary themes were identified. The research team met to discuss the codes, categories, and preliminary themes.

## **RESULTS**

## **SAMPLE**

A purposive sample of five insured adult patients from an academic medical center family medicine clinic was utilized in two focus group sessions. This population was patients who had been identified as super-users of the ED (>1 ED visit in any 30 day period in a 12 month period) and had established care at the Family Medicine Clinic. Although only three individuals participated in the first focus group, two in the second focus group, a total of ten were invited. 60% of the sample was Caucasian females. Two participants were African American. The mean age of the participants was 46 years (range of 20 to 56 years).

## **PRELIMINARY THEMES**

The themes that have emerged from the data analysis are preliminary due to ongoing recruitment and data collection. Two primary factors were found to help some participants access and engage in primary care, however, these same factors hindered access for other participants. These preliminary themes are (1) Perceptions of a collaborative relationship with the provider impacts decision to seek care and (2) Support systems effect sustained engagement in health care services. Interestingly, unique barriers to accessing primary care did not emerge through the analysis.

### **Theme: Perceptions of a collaborative relationship with the provider impacts decision to seek care.**

*Positive Impact: Increased likelihood of utilizing primary care services.* This preliminary theme conveys the value patients placed on their relationships with their providers. Participants expressed that they would wait longer to receive health care if they were able to see their personal provider. Clear communication also created trusting relationships between the patient and provider. One participant stated, "All of my doctors communicate

with each other with him about what's going on," and "I know them [the specialists] real well and they're really nice." Because the participants knew their primary providers were communicating with their specialists and the nurses were following up with the patients on the treatment plan, trust was enhanced.

Further, participants acknowledged the efforts by the clinic to accommodate patients' urgent needs. One participant stated, "He stays there till about like 7:00, 8:00 at night. It all depends on who his last patient is and everything, he stays there until they're done." One participant explained her satisfaction with short wait times: "All the [clinics] I've been through up here through XX I've got in and got out in no time." This level of accommodation observed by patients increased their likelihood of using primary care services.

*Negative Impact: Seeking health care from multiple or alternative sources.* Participants who did not have a quality working relationship with their primary care provider did not feel their health care needs were adequately met. External health services were pursued when there was a lack of trust and collaboration between the patient and the provider. A participant stated, "I think he's just rushing cause he's been pressured with the same situation, pain or whatever, I think he rushed it, but it just might be me." Patients feel they are not receiving comprehensive, quality care when they are not engaged in a collaborative relationship with the provider. One participant said, "I always get a second opinion though cause the doctor I'm seeing here we don't really see eye to eye no more." Because the patient perceives that the provider does not trust him, it negatively impacts his decision to seek care at the ambulatory care clinic. The participant stated, "That's why I go to

emergency because [my doctor stopped], you know, giving me the right shots, you know, whatever needed to be done.” The Emergency Department is perceived as accessible place to attempt to fulfill health care needs unmet by the provider.

**Theme: Familial, employer, and other external support systems effect sustained engagement in health care services.**

*Positive Impact: Increased accessibility to primary care services.* Participants acknowledged family members, community programs, and employers who assisted with engagement in health care services. Help and support from family members allowed participants to go to appointments. One participant stated, “I always have a way. My family’s pretty understanding, so if I need to go.” Other participants acknowledged community services that were able to provide necessary transportation to medical appointments when family members were not available. Participants also recognized employers as supportive of obtaining health services. A participant stated, “My work is understanding. They know my issue and I have been hospitalized many times since I have worked there and they are pretty understanding.” Individuals are better able to schedule health care visits when they do not fear losing their job or being otherwise reprimanded by employers.

*Negative Impact: Decreased likelihood of visiting clinics.* Inflexible work schedules and employer policies create barriers for patients to receive primary care. One participant stated, “Can’t take off work.” In this way, for some participants, employers hinder accessibility to health care. Furthermore, for participants who relied on family members for transportation, they could not visit clinics while family members were at work. A

participant recalled, “Everybody work in the daytime so normally at night time that’s when I would show up in the emergency room, because they all could get me there.” A lack of employment support for health care needs created barriers for participants to access care.

## DISCUSSION

In this qualitative study, we identified two preliminary themes that served as facilitators to accessing care for some participants while hindering access to care for others. We found that patients’ perception of a collaborative relationship with providers impacts their decision to seek care. Positive feedback was received for providers who cultivated a trusting relationship with their patients. Flexibility in scheduling appointments with physicians also increased accessibility to primary care for individuals. Subsequently, these patients relied on the clinic for coordination of all their health care needs. Patients did not prefer to visit the clinic when they experienced providers who rushed through appointments and did not actively listen to their concerns. They expressed needing Emergency Department services to receive unmet health care needs.

Some participants felt that their provider rushed through their appointments. Based on this identified perception, it would be beneficial for the Registered Nurse to be the last member of the health care team to see the patient and answer any remaining questions or address concerns. Approximately 10.5% of Registered Nurses in the United States are employed in ambulatory care settings (DHHS Health Resource and Services Administration, 2010). With few RNs, unlicensed assistive personnel historically have performed the majority of patient care tasks in ambulatory care settings. “The range of possibilities for RNs providing primary care is significant, and their capacity for filling these roles is not

always recognized” (Institute of Medicine, 2011, p. 55). Maximizing the roles of Registered Nurses in the clinic setting could improve relationships between patients and the health care team.

Additionally, adequate support systems allowed patients to make it to regularly scheduled appointments with primary care providers. Family and community programs provide transportation for individuals, which increase accessibility to health care services. The workplace also accommodates for individuals health care needs and supports access to primary care. However, those with inflexible work schedules perceived this as a significant barrier to scheduling appointments at clinics and accessing care. This would also potentially decrease ED use for chronic disease management. Patients who report less difficulty contacting their physician after hours have significantly lower rates of ED visits (30.4% compared to 37.7%). In the United States, approximately 29% of primary care providers provide care after hours (O’Malley, 2013). Flexible clinic hours or provider availability after regular clinic hours by phone or email would decrease unmet health care needs.

The researchers acknowledge some limitations to this study. In terms of the recruitment procedure, the participants who agreed to take part in the study may have been healthier, more physically able, and more motivated to attend appointments (such as the focus group session and clinic appointments), than those who declined to attend. The small sample size yielded very preliminary data and limits the transferability of the findings to a larger population. Further research is needed to more fully evaluate whether or not the larger population of ED super-users experiences the identified facilitators and barriers.



## CONCLUSION

This study is ongoing and the findings are preliminary. However, the positive effects of collaborative patient-provider relationships and strong support systems can have on access to and engagement in primary care are encouraging findings. The negative impact of poor patient-provider working relations and lack of support systems are important findings as well. These findings can facilitate improved efforts of behalf of the clinic to ensure all of the patients' needs are met.

## APPENDIX A

### FOCUS GROUP SEMI-STRUCTURED INTERVIEW GUIDE

Thank you for participating in this research study. You have been asked to participate because you sought healthcare at the emergency department and at that time were referred to \_\_\_\_\_. We are interested in finding out as much as we can about the things that prevented you from getting care at \_\_\_\_\_ clinic. We also want to find out what things helped you to access and stay in care at \_\_\_\_\_ clinic.

Tell me about your experiences with taking care of your health.

#### *Prompt Questions*

When you need health care, what do you do?

When you need health care, where do you go?

What things prevent you from getting care at a clinic?

Transportation?

Cannot get off from work?

Cannot find childcare?

Language barriers?

What makes it possible for you to go to a clinic?

What makes you decide to go to the emergency room?

#### *Prompts to elicit more information.*

Tell me more....

Help me understand....

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